Chapter Three

Budgetary Treatment of the Proposal

The *Budget of the United States Government* serves many purposes. Not only is the budget a financial accounting of the receipts and expenditures of the federal government; it also sets forth a plan for allocating resources--between the public and private sectors and within the public sector--to meet national objectives.

Ever since the outlines of the Administration's health proposal became known, policymakers and the media have expressed considerable interest in how it would be treated in the federal budget. Some observers contend that the program would not receive an appropriate degree of scrutiny if the budget did not include all of its financial transactions. If the financial activities mandated by the new program were not part of the budget, they argue, fiscal discipline might suffer: activities that are now in the budget might be transferred to non-budget entities that were not subject to the oversight and restraints characteristically imposed on budget accounts. Others fear that labeling all of the program's financial flows as budgetary might preclude a reasoned consideration of the proposal's merits by raising concerns about the size of the public sector. The choice of budgetary treatment could also affect which Congressional committees are given primary jurisdiction over the proposal.

The issue of budgetary treatment is not peculiar to the health reform initiative. Every time the Congress considers or enacts a bill that establishes a new program, the Congressional Budget Office and the Office of Management and Budget must consider whether and how it should be shown in the federal budget. For most pieces of legislation, this is a relatively easy call. But for some bills, such as major health reform proposals, that assessment is marked by some ambiguity and considerable complexity.

This chapter discusses the appropriate budgetary treatment of the Administration's health proposal, particularly the treatment of the payments to and from the regional and corporate alliances. It first examines the two main sources of guidance on budgetary classification--the *Report of the President's Commission on Budget Concepts* and the current budgetary treatment of programs analogous to the President's plan. It finds that these sources can inform the decision on how to treat the Administration's proposal but by themselves cannot resolve the issue.

The second and third sections of this chapter explain CBO's view: the financial transactions of the health alliances should be included in the accounts of the federal government, but they should be distinguished from other federal operations and shown separately, as is the practice for the Social Security program. CBO bases this view primarily on its judgment that the Administration's proposal would establish a federal entitlement to health benefits and that the mandatory premiums used to finance the new entitlement would constitute an exercise of sovereign power. CBO's view on these matters is only advisory; ultimately, the Congress and the President should explicitly address the issue through legislation to ensure the appropriate public control of and accountability for the transactions of the alliances.

Guidelines for Budgetary Classification

Certain elements of the Administration's proposal are unambiguously federal activities that all agree should be included in the budget--for example, the increase in the tax on tobacco, the subsidies for individuals and employers, the expansion of certain discretionary programs, and the changes in Medicare and Medicaid. But what about the premiums that individuals and employers pay to the health alliances and the payments by the alliances to the various health plans? Are the alliances private or state entities that belong outside the federal budget? Or are they, for most practical purposes, creatures of the federal government, whose income and outgo should all be included in the federal government's accounts?

In answering such questions, budget analysts normally consult two sources for guidance. One is the 1967 *Report of the President's Commission on Budget Concepts*. The other is budgetary precedents. Because of the unique features of the Administration's health proposal, neither source provides an unambiguous answer.

The President's Commission on Budget Concepts

In March 1967, President Lyndon B. Johnson appointed a 15-member commission to advise him on budgetary concepts and presentation. The commission issued its report in October of that year, and the budget that the President submitted in January 1968 reflected most of its recommendations--notably, the institution of a unified federal budget. The commission's proposal to record federal credit transactions in the budget on a subsidy-cost basis was not adopted until 1990, with the passage of the Federal Credit Reform Act. A few recommendations--for example, the use of accrual accounting instead of cash accounting--have never been fully implemented.

Although the *Report of the President's Commission on Budget Concepts* has no legal status, it remains to this day the only authoritative statement on federal budgetary accounting. The commission's most important recommendation was for a comprehensive budget with few exclusions. "To work well," the commission stated, "the governmental budget process should encompass the full scope of the programs and transactions that are within the Federal sector and not subject to the economic disciplines of the marketplace." The commission recommended that "the budget should, as a general rule, be comprehensive of the full range of Federal activities. Borderline agencies and transactions should be included in the budget unless there are exceptionally persuasive reasons for exclusion."[1]

The commission recognized that its recommendation posed "practical questions as to precisely what outlays and receipts should be in *the budget* of the federal government. The answer to this question is not always as obvious as it may seem: the boundaries of the federal establishment are sometimes difficult to draw." The commission proposed a series of questions to help make this determination: "Who owns the agency? Who supplies its capital? Who selects its managers? Do the Congress and the President have control over the agency's program and budget, or are the agency's policies the responsibility of the Congress or the President only in some broad ultimate sense? The answer to no one of these questions is conclusive, and at the margin, where boundary questions arise, decisions have been made on the basis of a net weighing of as many relevant considerations as possible."[2]

The report cited some exceptions, though, to its recommendation of a comprehensive budget. For example, even though the Federal Reserve System is clearly a federal operation, the commission recommended that its receipts and expenditures be excluded from the budget, in part to protect the independence of the nation's monetary authorities. The commission recommended that the local receipts and expenditures of the District of Columbia be excluded as well, even though the District is a federal

1. *Report of the President's Commission on Budget Concepts* (October 1987), pp. 24-25.

2. Ibid.

enclave. The commission further recommended that government-sponsored enterprises be omitted from the budget when such enterprises were "completely privately owned." Because the Administration's proposal shares some of the characteristics of these exceptions but lacks others, no one can be sure how the commission would have treated the health alliances, had they been on the horizon in 1967.

The commission also considered the issue of when to offset receipts against expenditures in presenting the government's fiscal totals. For fiscal year 1993, the Department of the Treasury reported federal outlays of $1,408 billion, federal governmental receipts of $1,153 billion, and a deficit of $255 billion. The figure for governmental receipts includes most of the funds that the government collects (for example, income and payroll taxes). But the budget treats some of the government's income, such as proceeds from the sale of stamps by the Postal Service, as an offset to its outlays.

"For purposes of summary budget totals," the commission recommended, "receipts from activities which are essentially governmental in character, involving regulation or compulsion, should be regarded as receipts. But receipts associated with activities which are operated as business-type enterprises, or which are market-oriented in character, should be included as offsets to the expenditures to which they relate." Among the various items that should be treated as budget receipts the commission listed both employment taxes and social insurance premiums.[3]

Budgetary Precedents

Another way to inform judgment is by examining relevant precedents. Yet this approach is also incomplete, because the Administration's health proposal differs significantly from existing programs and because existing accounting practices are inconsistent.

In one major instance--the unemployment insurance (UI) program--the federal budget includes in its entirety a joint activity of the federal and state governments. The Social Security Act of 1935 created the UI program and established a federal tax liability. Under the program, states are free to set tax rates, benefit levels, and eligibility requirements within certain limits. States that establish a federally approved UI system and impose their own payroll tax receive a partial credit against the federal UI tax. The federal tax pays for federal and state administration of unemployment insurance, 97 percent of the cost of employment services, and 50 percent of the cost of extended benefits during periods of high unemployment in a state. The state and federal taxes alike are deposited in trust funds held by the U.S. Treasury, and the federal budget records all of the funds' revenues and spending.

In other instances, the federal budget includes only part of the cost of a joint federal/state program. For example, if a state establishes a program of Medicaid or Aid to Families with Dependent Children that meets the terms of the Social Security Act, the federal government pays a prescribed share of the costs, and the budget includes only that federal payment. Unlike the case of unemployment insurance, however, the federal government imposes no tax or other penalty if a state fails to establish a Medicaid or AFDC program.

The Coal Industry Retiree Health Benefit Program is part of the federal budget, although its funds do not pass through the Treasury. Established by the Energy Policy Act of 1992, this program guarantees lifetime health benefits for certain miners and their dependents and requires coal companies to pay health insurance premiums to two privately managed trust funds on behalf of those miners, including some who never worked for the companies in question. Even though the benefit plans are nominally private and the federal government plays no role in selecting their trustees, the plans' receipts and spending are included in the federal budget because federal law both requires payment and determines the use of the money.

The budgetary treatment of the promotional boards for agricultural commodities is at odds with that of the Coal Industry Retiree Health Benefit Program. Federal law has established 17 of these boards since 1955. The boards collect assessments

3. Ibid., p. 65.

from domestic producers (and sometimes importers and marketers) and use those funds to promote consumption of a particular commodity, such as dairy products or cut flowers. The Secretary of Agriculture appoints most of the boards, and federal law establishes and enforces payment of the assessments. Yet despite this substantial federal role, the budget does not include the transactions of the boards.

Still other comparisons are possible between the Administration's proposal and various federal regulatory activities. For example, the federal government requires employers to meet conditions governing the wages and hours of workers (under the Fair Labor Standards Act of 1938), occupational safety and health (under the Occupational Safety and Health Act of 1970), and the treatment of persons with disabilities (under the Americans with Disabilities Act of 1990). All of these laws impose substantial costs on employers and may affect the amount and type of compensation that employees receive, but the budget includes none of their costs.

Looking at these budgetary precedents does not resolve the issue of how to treat the Administration's health proposal. The proposal bears a resemblance to all of the programs cited, but it also shows significant differences. Which is the most appropriate comparison? Is the proposal most like the unemployment insurance program, AFDC or Medicaid, the Coal Industry Retiree Health Benefit Program, the promotional boards for agricultural commodities, the mandates of the Americans with Disabilities Act, or some other program? The answer is, again, a matter of judgment. But even if the answer were clear, a practice followed for a program costing $200 million might not be appropriate for one costing $500 billion.

CBO's Assessment

Determining the appropriate budgetary treatment of a program like health reform involves answering not one but a series of questions. Is the program fundamentally governmental in nature, or does the legislation seek to facilitate, regulate, or guide an activity or transaction that remains essentially private? If the activity is primarily governmental, is it a federal activity, a state activity, a shared federal/state activity, or some new hybrid? If the answers to these two questions indicate that the program belongs in the accounts of the federal government, a third question arises: How should the program be displayed in, and controlled through, the budget?

Considering the Administration's proposal in its entirety, the Congressional Budget Office concludes that it establishes both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits. In administering the proposed program, regional alliances, corporate alliances, and state single-payer plans (if any) would operate primarily as agents of the federal government. Therefore, CBO believes that the financial transactions of the health alliances should be included in the federal government's accounts and that the premium payments should be shown as governmental receipts rather than as offsets to spending. Nonetheless, because of the uniqueness and vast size of the program, the budget document should distinguish the transactions of the alliances from other federal operations and show them separately, as is the practice for Social Security. CBO's view, as noted earlier, is solely advisory. The President and the Congress should ultimately resolve the debate over the proposal's budgetary treatment through legislation.

Why Should the Health Alliances Be Included in the Accounts of the Federal Government?

Two factors shape CBO's view that the proposed health alliances should be included in the federal government's accounts--a review of budgetary concepts and precedents and the need to ensure fiscal accountability and control. In addition, the public's perception of the nature of the new program deserves some consideration.

Budgetary Concepts and Precedents

More than a government regulation, the Administration's proposal specifies outcomes, dictates the means by which the outcomes must be achieved, prescribes the financing mechanism that must be used, and enforces the prescribed transactions. The first section of Title I creates a universal entitlement to a set of benefits that are defined in considerable detail. The benefits would not be restricted to those who already receive similar benefits, nor would nonpayment of premiums be grounds for a health plan or health alliance to deny benefits. Thus, the program does more than redefine the terms or conditions of preexisting private transactions, which is how one might characterize the minimum wage, for example.

The Administration's proposal establishes an explicit financing mechanism for the standard benefit package. It requires employers (except those large firms that choose to form corporate alliances), employees, and nonworkers to pay premiums to the regional alliances. A federal entity--the National Health Board--and a set of subsidies specified in federal law would largely determine the levels of those payments. The premiums would be mandatory, although many participants would undoubtedly pay them gladly in return for the program's health benefits, just as many would voluntarily contribute to Social Security in return for that program's retirement, survivors, and disability benefits. The proposal would also require states to make specified payments (for example, Medicaid maintenance-of-effort payments) to their regional alliances.

The National Health Board and the Departments of Health and Human Services and Labor would play important roles in the creation and day-to-day operation of the new health system. The board would approve the states' health care systems, impose sanctions on those systems that failed to meet federal requirements, develop a methodology for risk adjustment and reinsurance, set capital standards for health plans in the regional alliances, develop standards for states' guaranty funds, and oversee and monitor the system. The Secretary of Health and Human Services would develop standards for the financial management of the health alliances, audit the regional alliances, and certify essential community providers with whom plans would have to affiliate. The Secretary of Labor would be responsible for the proper functioning of the corporate alliances and could impose civil monetary penalties for noncompliance.

Although the federal government would play a very large role, the proposal would assign substantial responsibilities--and leave some discretion--to the states, the regional alliances, corporations, and individuals. States would establish and define the geographic boundaries of the regional alliances, ensure that the amounts owed to the alliances were collected and paid, assist alliances in verifying eligibility for subsidies, certify health plans and assure their fiscal solvency, ensure that all residents had access to an adequate choice of health plans, establish a reinsurance program for health plans, and provide a guaranty fund. If they chose, states could assign the responsibilities of the alliances to a state agency. They could also establish a single-payer plan, which would affect the amount of choice offered to the state's residents, the governance of the system, and (within specified limits) the system's financing.

The regional alliances would be charged with making agreements with qualified health plans and offering those plans to the residents of their areas. The alliances would ensure that people enrolled in health plans, collect premiums, determine eligibility for subsidies, evaluate the performance of health plans, ensure that the plans stayed within budget, adjust payments to plans for different levels of risk, establish fee schedules for services, and coordinate activities with those of other alliances. In addition, health plans in the regional alliances would offer participants the option of purchasing supplementary insurance to cover certain cost-sharing requirements of the standard benefit package and could offer supplementary insurance for items not included in the standard package. As proposed, the alliances' income from premiums and their payments to the health plans would not pass through the Treasury's accounts.

Large corporations would be able to establish corporate alliances that would perform the basic functions of regional alliances. Large corporations would also have some discretion in shaping the

options that their corporate alliances offered to employees. The Administration's proposal would impose no limits on the amount a corporation could initially pay for the insurance it provided to its workers, but it does specify the minimum fraction of the costs that the firm would have to pay and the rate by which premiums could grow. The premiums and payments would not flow though the regional alliances, and the subsidies to individuals would be largely the responsibility of the corporation, which would be required to pay at least 95 percent of the costs of insuring its low-wage workers. The proposal would require corporate alliances to offer at least three health plans (including one fee-for-service plan and two others, such as health maintenance organizations), employ community rating, use the same medical fee schedules as the regional alliances, and satisfy much the same requirements for information as the regional alliances.

Individuals in both regional and corporate alliances would have a choice of health plans, and their premiums would vary according to the plan they chose and their income. People would also have the option of purchasing supplementary health insurance.

Are these discretionary aspects of the proposal sufficient to classify the new program as a regulatory activity or a shared federal/state program? The answer to this question is a matter of judgment. No sharp line separates regulatory activities that are outside the budget from governmental activities that are within it. In this case, when the federal government specifies not only an outcome but also how the outcome is to be achieved, limits the ways in which the activity can be financed, makes a substantial financial contribution, and calls for the creation of new institutions to carry out the activity, CBO concludes that the boundaries of regulation have been crossed.

In particular, this appears to be the case with respect to the regional alliances. Federal statute would establish and define these new institutions. The terms and financing of the insurance they offered would be specified by federal law, and their activities would be regulated and monitored by the Departments of Labor and Health and Human Services. This situation differs from cases in which the federal government requires existing institutions--states or businesses--to take on added responsibilities and leaves open the choice of how they would finance them.

The corporate alliances, which have many of the characteristics of private entities, would for all practical purposes be standing in for a governmental or quasi-governmental agency--the regional alliance. If a large corporation chose not to establish its own alliance, it would have to participate in the regional alliances. If a corporate alliance did not comply with federal regulations or became financially insolvent, it could be terminated by the Secretary of Labor. If a state chose to establish a single-payer system, it could deny the large corporations operating within its borders the option of establishing a corporate alliance.

The important role and flexibility afforded to states and regional alliances do not appear to be sufficient to classify the proposal as a shared federal/state program like AFDC or Medicaid. Indeed, the level of federal involvement would far exceed that of existing entitlement grant programs. Regional alliances would be able to borrow from the federal government and would receive start-up grants from Washington. In addition, they would be granted powers that could only flow from federal authority. For example, they would have the power to extract premium payments from businesses in other states that employed their residents, even when those businesses engaged in no activity in the alliance's state. Federal law would establish a complex set of financial flows among alliances. Those flows would cover people who moved either temporarily or permanently, full-time students who attended schools located in other alliance areas, and multiworker families in which one or more workers could be covered by a corporate alliance.

As described in Chapter 1, federal agencies would play an important role in ensuring that states and alliances fulfilled the requirements specified in the proposal. If a state did not establish a system of alliances according to the law, or if the National Health Board terminated its approval of a state's system, the Secretary of Health and Human Services would establish and operate a system of alliances and would impose a surcharge of 15 percent on

premiums to cover additional administrative and other expenses. This backstop is even stronger than the one in the unemployment insurance program, which establishes a federal payroll tax liability that can be largely offset by state unemployment payroll taxes.

The universality of the entitlement distinguishes the Administration's health proposal from programs such as AFDC and Medicaid. In those two programs, states have the option of not participating. (Until 1982, Arizona did not participate in Medicaid.) The Administration's proposal would require everyone to participate; it would also require states to make specific payments to their regional alliances for noncash beneficiaries of Medicaid and for additional benefits for certain children receiving AFDC or Supplemental Security Income.

The significant financial role that payments from the U.S. Treasury would play in the new program reinforces the impression that it would be predominantly a federal, not a state, activity. By 2004, about 30 percent of the payments to the health alliances would be federal subsidies to low-income families and employers, payments for Medicaid beneficiaries, and the like. And the financial role of the Treasury in the regional alliances could grow even bigger if many Medicare recipients and military dependents currently receiving federal health services chose to participate in the alliances instead. In contrast, the states would have a much smaller financial role.

Even the voluntary aspects of the new program do not by themselves resolve the issue of budgetary treatment. The fact that individuals could choose the plan they wanted, and thus the premium they would pay, is balanced by the constraints that federal law and regulation would place on the benefits and the charges. The benefits and cost sharing would be set by legislation, and ultimately the National Health Board would limit the average premium in each area. The voluntary nature of supplementary cost-sharing insurance--people can decide whether or not to purchase it--must be weighed against the fact that federal law would define its scope, coverage, and availability. Moreover, the proposal would require that the premiums for cost-sharing supplements take account of the increased use of standard benefits by those people who had purchased the supplementary coverage. Furthermore, it is worth noting that the federal budget includes many voluntary transactions, not the least of which is physician insurance under Medicare.

On balance, the new program seems to represent an activity of the federal government that relies on the exercise of sovereign power. The universality of the entitlement, the mandatory nature of the premiums, and the major financial participation of the U.S. Treasury outweigh other considerations. Although the states and the alliances would have important roles and responsibilities, they would be acting largely as agents of the federal government.

Fiscal Accountability and Control

The second reason for including the health alliances in the federal government's accounts is the need for accountability and control. Since the alliances would be agents of the federal government, their financial flows should be subject to a level of oversight and control similar to that accorded programs that are included in the federal budget.

It is particularly important that the activities of the health alliances be subject to some fiscal restraints and limits as long as tight controls govern other federal activities. Discretionary appropriations are currently limited by caps on budget authority and outlays. Receipts and direct spending programs are constrained by pay-as-you-go rules. Social Security, which is classified as off-budget, is subject to its own set of rules, which are designed to prevent the depletion of the program's reserves.

The Administration's health proposal would establish many financial flows between the Treasury and the health alliances. Payments would flow from the Treasury to the alliances for subsidies to individuals and employers, for recipients of cash welfare benefits, and for Medicare beneficiaries who chose to stay in an alliance plan. The Treasury would receive payments from the alliances for graduate medical education and for participants who chose to get their health care through plans established by the Department of Defense, Department of Veterans Affairs, or Indian Health Service. If the

activities of the health alliances were not subject to fiscal control, the restraints on federal spending and receipts could easily be circumvented by altering these financial flows or creating new ones.

For example, the Congress could lower the mandatory payments that the federal and state governments would make to the alliances to pay for the health benefits of Medicaid cash beneficiaries from 95 percent of their previous payments to, say, 75 percent. If the alliances were exempted from the budgetary discipline imposed on most other federal activities, cutting those payments would appear to reduce federal spending and would add room on the pay-as-you-go scorecard, even if individuals and employers were required to pay higher health insurance premiums to cover the receipts lost to the alliances.

Similarly, the Congress could require health plans to cover needs and activities that are currently provided through discretionary appropriations, such as nutritional assistance for infants and pregnant women. This move would free up resources under the discretionary spending limits of the budget and make the health alliances bear added burdens if they were not subject to appropriate budgetary controls.

Increasing the limits on the percentage of their payrolls that employers contributed to the regional alliances would appear to have very different effects on the federal government's finances depending on how the budget treated the alliances. If the alliances were included in the government's accounts, higher employer payments would be recorded as an increase in governmental receipts. If the alliances were excluded, any rise in employers' payments would be shown as a spending cut, because it would reduce federal subsidies to the alliances.

Preventing budgetary gamesmanship requires that corporate alliances and state single-payer plans--not just regional alliances--be included in the federal government's accounts. Otherwise, legislation could create the semblance of budgetary savings by expanding the corporate alliances or by creating additional incentives for states to operate single-payer systems. Including the corporate alliances and the state plans would also avoid meaningless changes in the fiscal totals that could arise if several large firms terminated their corporate alliances or if the Secretary of Health and Human Services was forced to take over a state's system of alliances.

The Congress has several options available for controlling the financial activities of the health alliances. It could subject the alliances to the same fiscal controls that govern the rest of the federal government's activities, or set up a separate set of controls for them, or both. Without a full accounting and some sort of control, however, the income and outgo of the health alliances would escape the scrutiny that is essential when the federal government takes resources from individuals and businesses and uses them to meet a national objective.

Public Perception

Some policymakers and citizens may wonder whether including the health alliances in the federal government's accounts defies common sense and the public's perception of the nature of the new program. Why should the government's accounts show transactions that, for most workers, are like those that already occur in the private sector? The answer is that the budgetary status of a federal activity is not determined by whether the private sector provides the same service. Very few federal programs would be included in the budget if the criterion for inclusion were that there be no comparable private spending. Many federal programs that appear in the budget are largely an extension of prior practices in the private sector. For example, loans to businesses and individuals, medical research, and public safety programs are a few of the large number of federal programs that have displaced private spending to some degree.

Many of those people who now have employment-based health insurance might be surprised at first to be told that they had just become participants in a major new federal program, since under the new system they might be able to keep the same health plans that they now have and might enjoy much the same benefits. Currently, employers (or unions) make payments to insurance carriers that reflect both the employers' contributions and the employees' premiums (if any), which are deducted

from the workers' paychecks. In the new system, employers would make the same sorts of payments, but they would make them to an alliance, which would then transfer funds to the health plans that the workers had chosen.

What would differ is that federal law rather than the employer would determine the benefits and premiums. Moreover, the transaction would no longer be voluntary. The employer could not drop or change the terms of the health insurance benefit. Similarly, employees could not opt out of their employment-based plan, as some do now because they do not want to pay their share of the premium or because they are covered under a spouse's policy.

Those people who were receiving employment-based health insurance for the first time would initially be more accepting of the notion that they had become participants in a government program. Their employers, who would suddenly find themselves required to make payments for their employees' health insurance, would undoubtedly feel the same way. Many nonworking and self-employed individuals with adequate incomes who currently choose to remain uninsured would probably conclude that they were part of a government program as well.

Why Should the Health Alliances Be Shown Separately?

Although CBO's analysis has concluded that the health alliances would be more like federal agencies than like state or private entities, it has also found that the Administration's proposal would be unique in its form, size, scope, and complexity. In addition, the funds earmarked for the health alliances are not intended to be used for any other federal program. These features of the proposal argue for showing its transactions separately in the federal government's accounts rather than mixing them with other federal activities.

The institutions and responsibilities that the Administration's proposal would create would be unlike those of any existing federal program. The flows of premiums and spending into and out of the alliances would dwarf the income and outgo of Social Security, which is currently the largest federal program (see Table 2-5). The complexity of the structure would be unprecedented, with regional alliances, corporate alliances, and possibly state single-payer plans interacting with each other and with numerous private health plans, Medicare, Medicaid, the Veterans Affairs and Indian health systems, the Defense Department's health plans for military dependents, and the federal subsidy system. A separate budgetary accounting would make clear the size of the program and its effect on federal receipts and outlays.

Like Social Security, which is treated as off-budget but included in the federal government's consolidated accounts, the Administration's health proposal would be financed from earmarked revenues, except for the subsidies and other explicit payments from the U.S. Treasury and the states. Segregating the finances of the alliances from other federal programs would reflect the earmarked nature of the premiums and highlight the additional subsidies required.

Several practical considerations constitute further grounds for segregating the finances of the health alliances. Unlike the funds of almost all other federal programs, those of the alliances would not flow through the U.S. Treasury. At least initially, then, their financial data--particularly the reports from the corporate alliances--are likely to be of poorer quality than those of programs currently in the budget. The Coal Industry Retiree Health Benefit Program illustrates this point: despite its being in the budget, its funds do not pass through the Treasury, and problems with data collection have thus far prevented its inclusion in the *Monthly Treasury Statement of Receipts and Outlays of the United States Government.*

Table 3-1 illustrates the budgetary display that CBO suggests for the Administration's proposal. Federal outlays for premium and cost-sharing subsidies, Medicare, and Medicaid, and federal receipts from income and excise taxes (see Table 2-2) would be shown on-budget. Changes in Social Security benefits and payroll taxes would be shown off-

budget. The net outlays and nonfederal receipts of the health alliances (see Table 2-5) would be shown in a new off-budget category, the way Social Security is shown today, and included in the federal government's consolidated totals. Because the health alliances are expected to balance their income and outgo, including them in the totals would have no significant effect on the deficit. But the alliances' payments to health plans would swell federal outlays, and mandatory payments of health insurance premiums by firms and individuals would add to federal receipts.

Maintaining a separate accounting for the health alliances would not stand in the way of obtaining a complete picture of the impact of the federal sector on the economy. The consolidated totals would reveal "the full scope of the programs and transactions that are within the federal sector and not subject to the economic disciplines of the marketplace," as the President's Commission on Budget Concepts recommended, and would allow policymakers and the public to evaluate the Administration's proposal in a comprehensive fashion. But keeping the health alliances separate would make clearer the many complex interactions among the proposal's components and would recognize and accommodate the proposal's unique aspects, which prevent it from fitting neatly into any existing budgetary pigeonhole.

Table 3-1.
Suggested Budgetary Display of the Administration's Health Proposal, Fiscal Year 2004 (In billions of dollars)

	Outlays	Receipts	Surplus or Deficit (-)
CBO Baseline			
On-Budget	2,007	1,503	-503
Off-Budget			
Social Security	412	550	138
Postal Service	0	0	0
Consolidated Total	2,419	2,054	-365
Effect of the Proposal			
On-Budget	52	44	-7
Off-Budget			
Social Security	2	9	8
Postal Service	0	0	0
Health alliances[a]	513	513	0
Consolidated Total	566	566	b
Baseline with the Proposal			
On-Budget	2,058	1,548	-510
Off-Budget			
Social Security	414	559	146
Postal Service	0	0	0
Health alliances[a]	513	513	0
Consolidated Total	2,985	2,620	-365

SOURCE: Congressional Budget Office.

a. Receipts of the health alliances would comprise premiums from employers and households and payments by state governments. Federal transactions with the health alliances would be treated as intragovernmental outlays.

b. Less than $500 million.

Conclusion

Two aspects of the Administration's health proposal have made its budgetary treatment particularly contentious. First, the proposal is innovative and complex, and existing budgetary concepts and precedents are less helpful than usual. Second, the proposal does not spell out the requirements for financial reporting by the federal government or the fiscal rules controlling the system of regional and corporate health alliances.

For these reasons, the Congress will want to consider carefully the budgetary presentation and control of the health alliances in its deliberations on the Administration's proposal. If the Congress decided to include the income and outgo of the alliances in the federal government's accounts, it could facilitate their recording and control by requiring them to flow through the Treasury. In any event, the Congress should require the federal government to provide regular financial reports on the health alliances and should bring the alliances under some form of fiscal discipline to ensure that existing budgetary rules are not circumvented.